STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGUALTION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 89801-001**

v

Priority Health Insurance Company
Respondent
_____/

Issued and entered
this 24th **day of July 2008**
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On May 14, 2008, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. After a preliminary review of the material submitted, the Commissioner accepted the request on May 22, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the insurance policy issued by Priority Health Insurance Company (PHIC). The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

The Petitioner receives health care benefits under a preferred provider organization (PPO) group health plan. The plan has a network of medical care providers who have agreed to furnish medical care for specified fees. While providers who are not in the PPO network may

also furnish medical care to those insured by the plan, services from non-network providers generally result in more out-of-pocket costs.

On July 18, 2007, the Petitioner was taken to the emergency room at XXXXX, a network hospital, where she was later admitted as an inpatient. On the same day her attending physician recommended an MRI/MRA test and she was taken by ambulance to XXXXX because XXXXX did not have the equipment to provide the test. FHSIC is a non-network provider.

PHIC covered the services, applying a copayment for the ambulance service and covering the MRI/MRA test as a non-network benefit. The Petitioner appealed, asking for a waiver of the ambulance copayment and coverage of the MRI/MRA at the network level. PHIC denied her request, saying it applied the copayment and coinsurance in accordance with the terms of the policy.

The Petitioner exhausted PHIC's internal grievance process and received its final adverse determination letter dated April 3, 2008.

III
ISSUE

Did PHIC correctly process the Petitioner's claims for the ambulance service and MRI/MRA test under the terms of her policy?

IV
ANALYSIS

Petitioner's Argument

The Petitioner was receiving inpatient treatment for vertigo caused by an inner ear problem. A CT scan indicated the possibility of an aneurysm and her physician recommended an MRI/MRA. She went by ambulance to the nearby XXXXX and had the tests. As a result she had to pay a $50.00 copayment for the ambulance service and 30% of the allowed charge for the MRI/MRA.

The Petitioner says she was unaware that XXXXX was not part of the network hospital

and was not informed that it was a non-network provider. She further said that she had no control over where she was sent for the MRI/MRA; given a choice, she would have elected a network provider.

The Petitioner says that the policy's schedule of benefits indicates that inpatient services at a network hospital are covered 100%. Since she was a patient in a network hospital, she expected that all services would be covered and did not think she would have to check to see if the MRI/MRA provider was in the PPO network. She says if the network hospital had been equipped to perform the MRI/MRA test, she would not have incurred out-of-pocket expenses.

The Petitioner wants PHIC to waive the $50.00 ambulance copayment and cover the MRI/MRA test at the network level.

PHIC's Argument

PHIC contends that the Petitioner's services were processed appropriately. The policy's "Schedule of Benefits," which contains the copayment and coinsurance provisions for ambulance and imaging services, is excerpted here:

Benefits	Network Benefits	Non-Network Benefits
Medical Emergency and Urgent Care Services		
Ambulance Services	$50.00 Copayment	$50.00 copayment
OTHER SERVICES		
Radiology Examinations and Laboratory Procedures	• 100% Coverage • High-tech imaging services require prior approval. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums	• 70% Coverage of Reasonable and Customary Charges • High-tech imaging services require prior approval. Failure to obtain prior approval will result in a $250.00 reduction in benefits. • Deductible applies • Amounts paid after deductible do apply toward out-of-pocket maximums

According to PHIC, it correctly applied the copayment and coinsurance in accordance with the terms of the policy.

Commissioner's Review

In this case, the Commissioner's authority under the Patient's Right to Independent Review Act is limited to deciding if PHIC followed the terms and conditions of the Petitioner's policy when processing her claims for the ambulance service and the MRI/MRA. The Commissioner finds that it did and upholds PHIC's final adverse determination.

PHIC says that it determines benefits based on the status of the provider (network or non-network) at the time of service. The policy's "Schedule of Benefits" determines how benefits will be paid. The schedule (shown above) is clear that there is a $50.00 copayment for ambulance services (whether network or non-network), and there is no dispute that the Petitioner was transported via ambulance to XXXXX. The schedule also indicates that radiology benefits from a non-network provider are covered at 70% of the reasonable and customary charge. From the material in the record, it is apparent that PHIC followed these policy provisions when processing the Petitioner's claims.

It is unfortunate that the Petitioner was not aware that XXXXX was a non-network provider. She is understandably upset that she incurred out-of-pocket expenses for services that might otherwise have been covered fully. However, even if the Petitioner was not informed about the network status of XXXXX or did not, under the circumstances, have the opportunity to choose a network provider, PHIC did not violate the terms of the policy. The policy has this statement on page 12:

> You are responsible for determining whether a provider is part of the Network before receiving services. Unless otherwise specified in this Policy, benefits will be paid based on the Network status of the provider as of the day that services are received.

The policy also says (page 34): "Services you receive from Non-Network Providers will be paid at the Non-Network Benefits level."

The Petitioner received ambulance services and had radiology tests performed by a non-network provider. The Commissioner can find nothing in the policy that would require PHIC to waive the ambulance copayment or process her MRI/MRA claim as a network benefit, even given the facts of the Petitioner's case.

V
ORDER

The Commissioner upholds PHIC's April 3, 2008, final adverse determination in this case.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.